

NOTES

(0920) Received at from the best of unusual hemia repair. At 1 amenable on chills at response to week actually Mon. in stone SB in 405 pulse of 100% on day 10 after the most things clear. At the (0935) At this morning quietly keep deep even at included. There is to gain actually dry (1st) (0950) Encouraged at to make up HBB (0945). At dawn had the 020 this time. He made removed. 02 sat 099% on room air (1000) 02 sat 100% in 02. At this change instructions given to at 1st bed and underpunding Discharged from PACU. VS remain stable. *Steffen R*

Discharge Notes

Dressings

(K) groin

Drains

Ø

Tubes

Ø

I/V's

Saline lock

IV

INTAKE/OUTPUT Void

OR 450 PO Ø Ø

PACU 100

POST OPERATIVE INSTRUCTIONS

Medications

Percocet 1-11 R
8 60 pm Prii

Intake/Output

Wound Care

I ce to incision x 24
Clean daily, 2 H2O2
No tobacco

Diet

Neonate pre-vious

Safety Measures

Other

REPORT GIVEN TO:

A. Williams

Patient's Statement of Understanding

Understand

DISPOSITION OF PATIENT

☒ PATIENT ROOM 504

☐ TRANSFER TO LOCAL HOSPITAL

☐ OTHER

☐ PACU CONTINUED RECOVERY

**MICAL CENTER
 RAL PRISONERS
 IELD, MISSOURI**

PATIENT IMPRINT

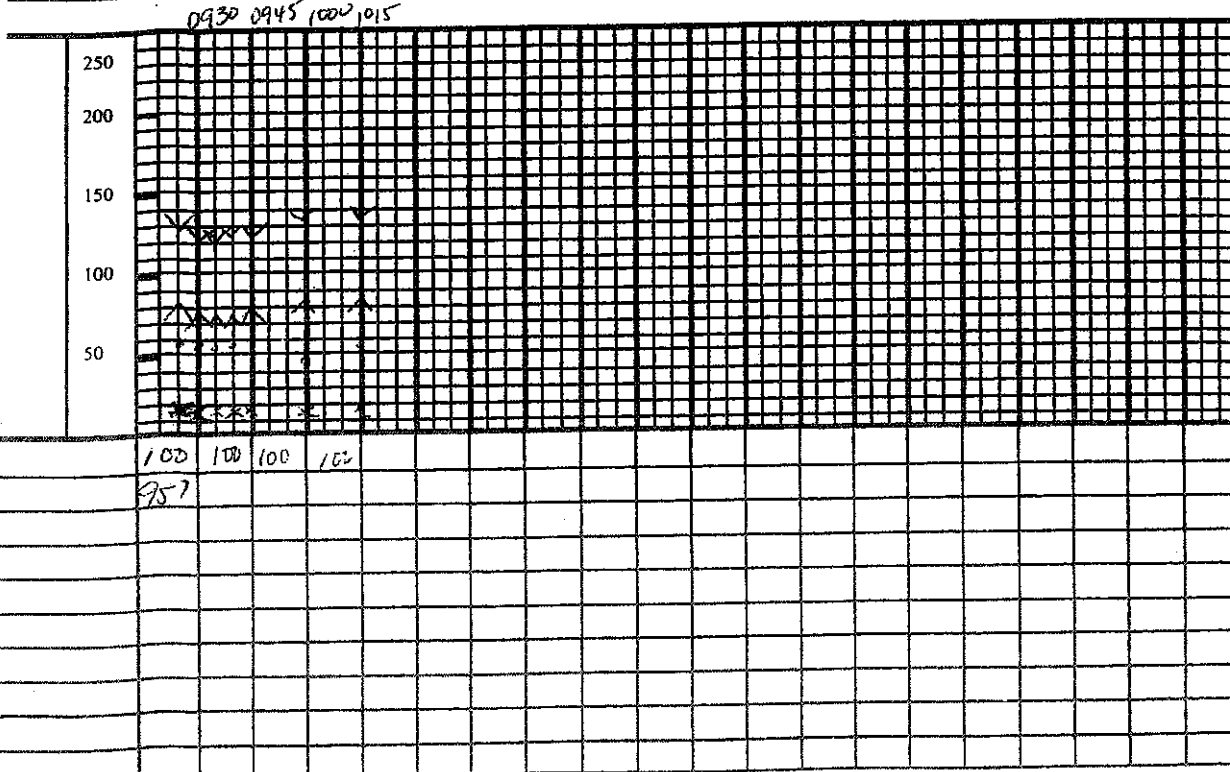
PACU RECORD

E-OP DIAGNOSIS <u>Hernia</u>	AGE <u>39</u>	SEX <u>M</u>	HT <u>70</u>	WT <u>200</u>
ANESTHETIST <u>Hipkins</u>	SaO ₂ <u>97</u>	BP <u>138/81</u>	T <u>96</u>	P <u>70</u>
URGON ASSO'S <u>Rolton, D.</u>	PS <u>1 2 3 4 5 E</u>			
PERATION <u>Repair Right Inguinal Hernia w/ plug & patch</u>	ALLERGY <u>NKDA</u>			
PATIENT HISTORY <u>HTN Hemorrhoids</u>				

<u>Hipkins</u>	MD/CRNA	RECEIVED BY <u>Scott Giffen</u>	R.N.
Other <input type="checkbox"/>			
IV Sed. <input type="checkbox"/>			
E.T.T. <input type="checkbox"/> None			
@ <u>10</u> l/min			
<u>LR</u>			
<u>SD</u>			
<u>R/groch</u>			

POST-ANESTHESIA RECOVERY SCORE		IN	15	30	45	HR	OUT
ACTIVITY	4 EXTREMITIES	2	2	2	2	2	2
	Able to move voluntarily or on command	1	1	1	1	1	1
	0 EXTREMITIES	0	0	0	0	0	0
RESPIRATION	Able to deep breathe and cough freely	2	2	2	2	2	2
	Dyspnea, shallow, or limited breathing	1	1	1	1	1	1
	0	0	0	0	0	0	0
CIRCULATION	BP ± 20mm of Preanesthesia Level	2	2	2	2	2	2
	BP ± 20-50 mm of Preanesthesia Level	1	1	1	1	1	1
	Pre-Op BP <u>138/81</u> BP ± 50 mm of Preanesthesia Level	0	0	0	0	0	0
CONSCIOUSNESS	Fully Awake	2	2	2	2	2	2
	Arousable on calling	1	1	1	1	1	1
	Not Responding	0	0	0	0	0	0
COLOR	Normal	2	2	2	2	2	2
	Pale, Dusky, Blotchy, Jaundiced, Other	1	1	1	1	1	1
	Cyanotic	0	0	0	0	0	0
TOTAL		8	9	9	10		

Route	Time	Given By	Medication/Dose	Route	Time	Given By



U. S. MEDICAL CENTER for FEDERAL PRISONERS
Springfield, Missouri

INDIVIDUAL EVALUATION/TREATMENT/MANAGEMENT PLAN

Goal Statement #1: Recovery from anesthesia.

1. The patient recovers from anesthesia without untoward effects.

Objectives:

1. The patient will remain free of respiratory distress.
2. Maintain stable Vital Signs (VS).
3. Maintain control of bleeding and dysrhythmias.
4. Maintain adequate urinary output.
5. Maintain a reasonable level of comfort and be discharge instructions.
6. Able to express an understanding of discharge instructions.

Action Plan: (Include staff name and title) *Scott Griffith RN* S. GRIFFITH, RN, C

1. Maintain airway. Suction prn. Assess respirations and monitor SaO₂. Give O₂ per anesthesia.
2. VS every 5-15 minutes. Continuous cardiac monitor. I&O.
 - ☐ IV fluids: _____
 - ☐ Blood: _____
 - ☐ Medications: _____
3. Assess level of consciousness (LOC) and ability to move extremities. Turn, cough, and deep breathe (TCDB) on command.
4. Gag and swallowing reflexes returned
5. Assess comfort measures:
 - ☐ Positioning: _____
 - ☐ Elevation: _____
 - ☐ Ice bag: _____
 - ☐ Medications per anesthesia: _____
5. Briefly explain to the patients subject related to the; treatment, plan, medications, diet, activity, and tubes. Answer questions.
6. Discharge when criteria met to ward of residence or 1-4.
7. Assess special needs: _____

Target Date: 1/9/07 Treatment Review: _____

NAME/REGISTER NUMBER

ALLEN, ANTHONY
 40428-053
 MCFP SPG MO
 DOR 3-2-54

USMCFP-Springfield, MO/jdd

ANESTHESIA RECORD		Diagnosis		Procedure		START STOP	
Date	OR No.	Page of		Repair Rnd	Aug & Mesh	Anesthesia	
1-9-04	1	1	Rt Ild	Rotten		0820	0920
						Procedure	0832 0910
PRE-PROCEDURE		MONITORS AND EQUIPMENT		ANESTHETIC TECHNIQUE		AIRWAY MANAGEMENT	
<input type="checkbox"/> Identified <input type="checkbox"/> Chart Reviewed <input type="checkbox"/> NPO Sina <input type="checkbox"/> Pre-anesthetic State <input type="checkbox"/> Awake <input type="checkbox"/> Apprehensive <input type="checkbox"/> Uncooperative <input type="checkbox"/> Taped		<input type="checkbox"/> Steth: <input type="checkbox"/> Precord <input type="checkbox"/> Esoph <input type="checkbox"/> Other <input type="checkbox"/> Non-invasive B/P: <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Continuous EKG <input type="checkbox"/> Pulse Oximeter <input type="checkbox"/> End Tidal CO ₂ <input type="checkbox"/> Temp. <input type="checkbox"/> Warming Blanket <input type="checkbox"/> NG / OG Tube <input type="checkbox"/> Art. Line <input type="checkbox"/> CVP <input type="checkbox"/> PA Line <input type="checkbox"/> IV(s)		<input checked="" type="checkbox"/> General: <input checked="" type="checkbox"/> Pre-Oxygenation <input type="checkbox"/> L.T.A. <input type="checkbox"/> Rapid Sequence <input type="checkbox"/> Cricoid Pressure <input type="checkbox"/> Intravenous <input type="checkbox"/> Inhalation <input type="checkbox"/> Intramuscular <input type="checkbox"/> Rectal <input type="checkbox"/> Regional: <input type="checkbox"/> Spinal <input type="checkbox"/> Epidural <input type="checkbox"/> Axillary <input type="checkbox"/> Bier Block <input type="checkbox"/> Ankle Block <input type="checkbox"/> Prep <input type="checkbox"/> Local <input type="checkbox"/> Needle <input type="checkbox"/> Drug(s) <input type="checkbox"/> Dose <input type="checkbox"/> Attempts x <input type="checkbox"/> Site <input type="checkbox"/> Level <input type="checkbox"/> Catheter <input type="checkbox"/> See Remarks Other: <input type="checkbox"/> M.A.C. <input type="checkbox"/>		<input type="checkbox"/> Intubation: <input type="checkbox"/> Oral Tube size 8 <input type="checkbox"/> Stylet used <input type="checkbox"/> Nasal <input checked="" type="checkbox"/> Magill's <input type="checkbox"/> Direct <input type="checkbox"/> RAE <input type="checkbox"/> Fiber optic <input type="checkbox"/> Blind <input type="checkbox"/> Armored <input type="checkbox"/> Secured at 22cm <input type="checkbox"/> LMA <input type="checkbox"/> Laser <input type="checkbox"/> Attempts x 1 <input type="checkbox"/> ET CO ₂ present <input type="checkbox"/> Breath sounds <input type="checkbox"/> Uncuffed, leaks at cm H ₂ O <input type="checkbox"/> Cuffed <input type="checkbox"/> Min. occ. pres. <input type="checkbox"/> Air <input type="checkbox"/> NS <input type="checkbox"/> Airway: <input type="checkbox"/> Oral <input type="checkbox"/> Nasal <input type="checkbox"/> Difficult <input type="checkbox"/> Circuit: <input type="checkbox"/> Circle <input type="checkbox"/> NR see Remarks <input type="checkbox"/> Mask Case <input type="checkbox"/> Nasal Cannula <input type="checkbox"/> Via Tracheostomy <input type="checkbox"/> Simple O ₂ mask	
PATIENT SAFETY						RECOVERY	
<input type="checkbox"/> Aries Machine <input type="checkbox"/> Safety Belt On <input type="checkbox"/> Amboboard Restraints <input type="checkbox"/> Pressure Points checked and padded <input type="checkbox"/> Eye Care: <input type="checkbox"/> Ointment <input type="checkbox"/> Saline <input type="checkbox"/> Taped <input type="checkbox"/> Pads <input type="checkbox"/> Goggles						Location PACA Time 0920 B/P 130/80 O ₂ Sat 95% P 46 R 18 T 35.7 <input type="checkbox"/> Awake <input type="checkbox"/> Stable <input type="checkbox"/> Nasal Oxygen <input type="checkbox"/> Drowsy <input type="checkbox"/> Unstable <input type="checkbox"/> Mask Oxygen <input type="checkbox"/> Somnolent <input type="checkbox"/> Intubated <input type="checkbox"/> T-piece Oxygen <input type="checkbox"/> Unarousable <input type="checkbox"/> Ventilator <input type="checkbox"/> Oral/nasal airway Recovery Notes Responds	
						FLUID TOTALS	
						Crystallloid 450 EBL — Blood — Urine —	
						PRE-OP PATIENT EVAL:	
						ASA 1 2 3 4 5 E AGE 39 HT. 6'1" WTG 196 KG ALLERGIES NKDA Hgb 15.6 Hct 47.3 K+ 5 PLT 234	
						REMARKS	
						Machine Monitor. Supply Vcd	
						X @ pt in room monitor position	
						3 Pre-Op Induced	
						ETRS Difficultly	
						4 Rooming in 3rd floor	
						Spont Resp Established	
						Responds to PAR	
						SYMBOLS	
						<input checked="" type="checkbox"/> ANESTHESIA <input type="checkbox"/> OPERATION <input type="checkbox"/> B/P CUFF PRESSURE <input type="checkbox"/> ARTERIAL LINE PRESSURE <input type="checkbox"/> MEAN ARTERIAL PRESSURE <input type="checkbox"/> PULSE <input type="checkbox"/> SPONT RESP <input type="checkbox"/> ASSISTED RESP <input checked="" type="checkbox"/> CONTROLLED RESP <input type="checkbox"/> TOURNIQUET	
TIME						TOTALS	
Oxygen							
N ₂ O							
Fentanyl							
Propofol							
Vecuronium							
Rohib. 2mg							
UR 1000							
Urine							
EBL							
EKG							
% O ₂ inspired							
O ₂ Saturation							
End Tidal CO ₂							
Temp.: °C °F							
Baseline Values							
B/P							
P							
R							
Tidal Volume							
Resp. Rate							
Peak Pressure							
PEEP							
Symbols for Remarks							
Patient Identification							
Anesthesia Provider							
TOURNIQUET #1							
↑ HRS. TORR							
↓ HRS. MIN							
TOURNIQUET #2							
↑ HRS. TORR							
↓ HRS. MIN							

DO NOT THINK

PREANESTHESIA EVALUATION		Age	Sex	Height	Weight
Proposed Procedure 1/9 RTH Repair		39	M	161 in / cm	196 lb / kg
Previous Anesthesia / Operations		None <input type="checkbox"/>		Current Medications B/P 145/90 P 80 R T 97.5	
Family History of Anesthesia Complications		None <input type="checkbox"/>		Allergies <input type="checkbox"/>	
AIRWAY / TEETH / HEAD & NECK		History From: <input checked="" type="checkbox"/> Patient <input type="checkbox"/> Significant Other <input type="checkbox"/> Parent / Guardian <input type="checkbox"/> Chart <input type="checkbox"/> Communication / Language Problems <input type="checkbox"/> Poor Historian			
SYSTEM	WNL	COMMENTS		DIAGNOSTIC STUDIES	
RESPIRATORY	<input type="checkbox"/>	Tobacco Use: <input type="checkbox"/> Yes <input type="checkbox"/> No _____ Packs / Day for _____ Years		EKG 11/03 NSR R75	
Asthma Bronchitis COPD Dyspnea Orthopnea Pneumonia				Chest X-ray	
CARDIOVASCULAR	<input type="checkbox"/>	HTN & Tx'ment		Pulmonary Studies	
Abnormal EKG Angina ASHD CHF Dysrhythmia Exercise Tolerance					
HEPATO / GASTROINTESTINAL	<input type="checkbox"/>	Ethanol Use: <input type="checkbox"/> Yes <input type="checkbox"/> No Frequency _____ "Street Drug" Use: <input type="checkbox"/> Yes <input type="checkbox"/> No Frequency _____ RTH denonchords		Other	
Bowel Obstruction Cirrhosis Hepatitis / Jaundice Hx of Hem / Reflux Nausea & Vomiting Ulcers					
NEURO / MUSCULOSKELETAL	<input type="checkbox"/>			LABORATORY STUDIES	
Arthritis Back Problems CVA / Stroke / TIAs DJD Headaches / T ICP Loss of Consciousness				Hgb / Hct / CBC 12/29/03 15.0 / 47.3 / 7.3 / 234	
RENAL / ENDOCRINE	<input type="checkbox"/>			Electrolytes 149 / 104 / 16 5 / 29 / 12 / 85	
Diabetes Renal Failure / Dialysis Thyroid Disease Urinary Retention Urinary Tract Infection Weight Loss / Gain				Unanalysis	
OTHER	<input type="checkbox"/>	HIV HEP Ⓢ		Other	
Anemia Bleeding tendencies Cancer Chemotherapy Dehydration Hemophilia					
Problem List / Diagnoses		RTH		1 2 3 4 5 6 E	
Planned Anesthesia / Special Monitors		ICU EP			
Pre-Anesthesia Medications Ordered		PAIN MEDICATION		PAIN MEDICATION	
EVALUATOR SIGNATURE		DATE		TIME	
MIPSKIND DO		1/7/04		0845	
EVALUATOR SIGNATURE		DATE		TIME	
MIPSKIND DO		1/7/04		0845	



U.S. MEDICAL CENTER SPRINGFIELD, MISSOURI

PERIOPERATIVE NURSING ASSESSMENT AND CARE PLAN

Check or circle the appropriate answer.

PRE-OP ASSESSMENT

Date 1-9-04 Time 0730

INTRA-OP ASSESSMENT

POST-OP ASSESSMENT

Patient's Statement of Procedure: "Fix my hernia - right Inguinal"

VERIFICATION OF

 Patient by: ☒ Picture
☒ ID Band
☒ Consent ☒ Surgical Site

POSITIONS

 Positioned by: Self to Bed
☒ Supine ☐ Prone
☐ Lithotomy ☐ Jackknife
☐ L ☐ R Lateral
 Other: _____
 Placement of Safety Strap: Thighs

 TRANSFERRED BY: Dr. Hipskind / Uka
 TO: ☒ PACU VIA: ☒ OR Cart
☐ 1-4 ☐ Bed
☐ Qtrs. 0920 ☐ Other: _____
Report Given To: B. Painter R

PRE-OP TEACHING

Date 1-9-04 Time 0730Interpreter: Ø

ARM POSITION

L	R
X	X

along side
armboard
across chest

SKIN INTEGRITY

☒ Same as Pre-Op
☒ Grounding Pad Site Checked
 Other: _____

MENTAL/EMOTIONAL STATUS

☒ Alert ☐ Sedated
☐ Confused ☐ Comatose
☐ Apprehensive
☒ Oriented by person, place, time

POSITIONING AIDS

☐ Ax. Roll ☐ Pillows
☐ Chest Roll ☐ Shoulder Roll
☐ Stirrups ☐ Heel/Elbow Pads
☒ Gel Pads
 Other: _____

RESPIRATORY STATUS

☒ Spontaneous ☐ Assisted
☐ Oral Airway ☐ ET Tube
☐ Trach ☐ Ambu Bag
☒ Oxygen @ 10 l/min
Intact yes ☐ no SKIN
 COLOR: ☒ Pink ☐ Pale
☐ Flushed ☐ Jaundiced ☐ Cyanotic

TEMPERATURE/CONDITION:

☐ Cool ☒ Warm ☐ Hot
☒ Dry ☐ Diaphoretic

LINES/DRAINS

☐ NA
☒ Peripheral IV ☐ NG Tube
☐ CVP ☐ Foley Catheter
☐ J-P Size: ☐ Penrose

RESPIRATORY

☒ Unlabored ☐ Labored
☐ Minimal Distress ☐ Ambu Bag
☐ Trach ☐ ET Tube
☐ Oxygen @ _____ l/min

PREP

 Betadine ☐ Gel ☐ Soap ☒ Solution
 Other: _____
 Shave: Clippers ☐ N/A
 by: Ray
 area: Right Inguinal area

Location: _____

Other: _____

CATHETERS/DRAINS/IVS

Present ☒ yes ☐ noDescribe: IV Left handCATHETER ☒ N/A

Size: _____

Inserted by: _____

Color/Amount: _____

COMMENTS: _____

DRESSINGS/PACKINGS

☐ NA
 Type: Primapore
 Tape: _____
NPO ☐ NA ☒ yes ☐ noSince: 2400 per patientAllergies: None known

LOCAL ANESTHESIA

DISCHARGE INSTRUCTIONS ☒ N/A
 Instructions as per physician's orders discussed with
 pt. ☐ yes ☐ no

AGE SPECIFIC ASSESSMENT

☒ Young Adult ☐ Older Adult
☐ Middle Adult

COMMENTS: _____

COMMENTS: _____

COMMENTS:

No Dentures
operative site marked
by Dr. Rotton

R.N. Signature

Ray (Linda Ray)

R.N. Signature

Ray (Linda Ray)

R.N. Signature

Ray (Linda Ray)

ADDRESSOGRAPH:

 ALLEN, ANTHONY
 40428-053
 MCFP SPG MO
 DOB 3-2-64



U.S. MEDICAL CENTER SPRINGFIELD, MISSOURI

INTRAOPERATIVE REPORT

Date: <u>1-9-04</u>		OR # <u>1</u>		Wound Class: <u>T</u>	
TIMES:	Pt. In	Induction	Incision	Closure	Pt. Out
Procedure #1	<u>0820</u>	<u>0820</u>	<u>0832</u>	<u>0910</u>	<u>0920</u>
Procedure #2					

Pre-Operative Dx.: Right Inguinal hernia

Procedure: Repair of right Inguinal hernia with insertion of mesh Plug and patch

Post-Operative Dx.: Same

Anesthesia Type: General X Regional _____ ☐ IV Sed. ☒ Local ☐ None

Anesthesia Staff: Dr Hipskind ☐ Topical

Surgeon: D. Patten First Assistant: S. Slous RW

Second Assistant: _____

Circulator: L. Ray RW Relief: _____ In: _____ Out: _____

Scrub: M. Crom ST Relief: _____ In: _____ Out: _____

Other Persons Present: _____ Title: _____

COUNTS	Correct	Incorrect	NA	ESU	<input type="checkbox"/> Bipolar	<input type="checkbox"/> NA
Sponge	<u>X</u>			Serial # <u>C1118711</u>		
Sharps	<u>X</u>			Coag @ <u>36</u>		Cut @ <u>30</u>
Instr.			<u>X</u>	TOURNIQUET <input checked="" type="checkbox"/> NA		

Verified by: M. Crom ST / L. Ray RW

SPECIMENS		Source: <u>Right Inguinal</u>	
Pathology	<input type="checkbox"/> NA	<u>hernia sac</u>	
Cytology	<input checked="" type="checkbox"/> NA		
Culture	<input checked="" type="checkbox"/> NA <input type="checkbox"/> Fungus <input type="checkbox"/> Routine <input type="checkbox"/> AFB <input type="checkbox"/> Aerobic <input type="checkbox"/> Anaerobic		
Site: _____			INDICATORS
X-ray / C-arm During Procedure			EKG Lead <u>o</u>
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> NO X-ray Staff: _____			ESU Pad <input type="checkbox"/>
IMPLANTS:			IV <u>x</u>
<div style="display: flex; align-items: center;"> <div style="margin-left: 10px;"> <u>Right Inguinal</u> <u>Exp 3-2008</u> </div> </div>			Safety Strap <u>+</u>
Size: <u>Large Plug</u> REF <u>0112770</u> LOT <u>43CND094</u>			Elbow Pads <u>o</u>

COMMENTS: _____

MEDICATIONS <input type="checkbox"/> NA			ADDRESSOGRAPH
Medication	Dose	Route	
<u>Bacitracin 50,000 U / 100cc saline</u>		<u>Irrigation</u>	
<u>Marcaine 0.25% Plain 10cc</u>		<u>Injection</u>	

ALLEN, ANTHONY
40428-053
MCFP SPG MO
DOB 3-2-34

A. IDENTIFICATION

1. OPERATION OR PROCEDURE

REPAIR OF Right Inguinal HERNIA with plug and patch

B. STATEMENT OF REQUEST

1. The nature and purpose of the operation or procedure, possible alternative methods of treatment, the risks involved, and the possibility of complications have been fully explained to me. I acknowledge that no guarantees have been made to me concerning the results of the operation or procedure. I understand the nature of the operation or procedure to be:

The surgical procedure of repairing a protrusion of an organ or tissue through an abnormal opening (Description of operation or procedure in layman's language)

which is to be performed by or under the direction of Dr. Bolton, D.
On 05 scheduled (date)

2. I request the performance of the above - named operation or procedure and of such additional operations or procedures as are found to be necessary or desirable, in the judgment of the professional staff of the below - named medical facility, during the course of the above - named operation or procedure.

3. I request the administration of such anesthesia as may be considered necessary or advisable in the judgment of the professional staff of the below - named facility.

4. Exceptions to surgery or anesthesia, if any, are:

(If none, so state)

5. I request the disposal by authorities of the below - named medical facility of any tissues or parts which it may be necessary to remove.

6. I understand that photographs and movies may be taken of this operation, and that they may be viewed by various personnel undergoing training or indoctrination at this or other facilities. I consent to the taking of such pictures and observation of the operation by authorized personnel, subject to the following conditions.

- The name of the patient and his/her family is not used to identify said pictures.
- Said pictures be used only for purposes of medical/dental study or research.

(Cross out any parts above which are not appropriate)

C. SIGNATURES

(Appropriate items in Parts A and B must be completed before signing)

1. COUNSELING PROVIDER: I have counseled this patient as to the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above.

(Signature of Counseling Provider)

2. PATIENT: I understand the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above, and hereby request such procedure(s) be performed.

Signature of Witness, excluding members of operating team)

(Signature of Patient)

(Date and Time)

SPONSOR OR GUARDIAN: (When patient is a minor or unable to give consent): I, sponsor/guardian of understand the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above, and hereby request such procedure(s) be performed.

Signature of Witness, excluding members of operating team)

(Signature of Sponsor or Legal Guardian)

(Date and Time)

PATIENT'S IDENTIFICATION

(For typed or written entries give: Name-last, first,

MIDDLE NAME & REGISTRATION NO.)

middle, grade; date; hospital or medical facility)

** Mire el reverso para el español **

"This is a translation of an English-language document provided as a courtesy to those not fluent in English. If differences or any misunderstandings occur, the document of record shall be the related English-language document."

"La siguiente es una traducción de un documento en inglés que se provee como cortesía a los que no hablan o son fluentes en inglés. Si existe alguna diferencia o mal entendido, el documento original en inglés es el válido."

ALLEN, ANTHONY
40428-053
MCFP SPG MO
DOB 3-2-64

DO NOT THIN

DOCUMENTO

CARTA DE SOLICITUD

PARA LA ADMINISTRACION DE ANESTHESIA, PARA OBTENER TRATAMIENTOS QUIRURGICOS, O PARA OTROS PROCEDIMIENTOS MEDICOS

MEDICO

A. IDENTIFICACION

1. Operacion a Procedimiento (Tratamiento)

(Ver al reverso)

B. DECLARACION DE SOLICITUD

1. Me han explicado completamente la necesidad y el caracter (clase) de tal operacion (procedimiento quirurgico) o tratamiento medico (procedimiento). Igualmente, me han explicado metodos alternativos de tratamiento; y entiendo los riesgos y las complicaciones que pueden ocurrir. estoy de acuerdo, que no se me ha hecho ninguna garantia con respecto a los resultados de tal operacion o procedimiento. Entiendo que la operacion o tratamiento medico es el siguiente.

La cual sera ejecutada por/con la direccion del Dr. (Ver al reverso)

En (Ver al reverso) fecha

2. Solicito la operacion o tratamiento medico, mencionado anteriormente, y ademas, cualquier otra operacion o procedimiento que se encuentre necesario o deseable, conforme la opinion del cuerpo medico de la institucion medica, aqui nombrada; mientras que se ejecute tal operacion a tratamiento.

3. solicito la administracion de cual anestesia se considere necesaria o recomendable, conforme la opinion de los medicos profesionistas de la institucion medica, aqui nombrada.

4. Contradicciones o exclusiones, a esta cirugia o administracion de anestesia son, (si las hubiera): (Ver al reverso)
(si ninguna, declarelo así)

5. Solicito que las autoridades de la institucion medica, dispongan el destino final de los tejidos, o partes/miembros del cuerpo, que sea necesario extirpar (remover).

6. Entiendo que es posible, que tomen fotografias y peliculas de esta operacion; y que se pueden usar por razones de entrenamiento o instruccion, con estudiantes y empleados nuevos de esta o otra institucion. Doy permiso para que tomen estas fotografias y peliculas durante la operacion; y para que personas autorizadas puedan observar la operacion, de acuerdo con las siguientes condiciones:

- a. Esta prohibido, usar el nombre del paciente o de su familia, para identificar tal pelicula o fotos.
- b. dichas peliculas y fotos, se usaran unicamente por razones de estudio medico/dental y para investigaciones escolares de la medicina.

C. FIRMAS (Ver al reverso)

1. CONSEJERO: He aconsejado a este paciente sobre la necesidad y el caracter del procedimiento(s) anticipado, los riesgos, y el resultado posible de tal procedimiento(s), segun como esta aqui escrito anteriormente.

2. PACIENTE: Comprendo la necesidad y el caracter del procedimiento(s) anticipado, los riesgos, y el resultado posible de tal procedimiento, segun como esta aqui escrito anteriormente; y solicito tal operacion o procedimiento(s).

3. TUTOR O PERSONA RESPONSABLE: (Cuando el paciente sea menor de edad, o no sea capaz de dar su consentimiento): Yo, (Ver al reverso) Tutor/Person Responsable por Ver al reverso entiendo la necesidad y el caracter del procedimiento(s).

(FIRMA - VER AL REVERSO)

NSN7540-00-634-4176

600-108

HEALTH RECORD		CHRONOLOGICAL RECORD OF MEDICAL CARE	
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)		
	SAME DAY SURGERY ASSESSMENT		
1/9/04	Mode of Arrival: Ambulatory <input checked="" type="checkbox"/> Wheelchair <input type="checkbox"/> Gurney <input type="checkbox"/>		
0705	Reason for Admission: Repair of (R) Inguinal Hernia w/ plug & patch		
	Medical/Surgical History: See H&P		
	Allergies: NKAA		
	If Allergic, Reaction:		
	NPO since 1-08-04 VS: BP 139/81 P 70 R 20 T 96.1 SaO2 99 % RA		
	Height 6'1 Weight 198		
	Pain Assessment		
	Are you Having Pain?	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	0 1 2 3 4 5 6 7 8 9 10
	Location	Intensity	Frequency Duration
	Pre-op Teaching: Handout given: <input checked="" type="checkbox"/> Post-op Teaching: Handout given: <input checked="" type="checkbox"/>		
	Verbalizes understanding of pre and post-operative teaching:		
	Permit Signed: <input checked="" type="checkbox"/> Bracelet identification <input checked="" type="checkbox"/> To OR via gurney		
	Discharge from PACU: (See PACU Record)		Signature S. Robinson MIA
DISCHARGE FROM 1-4:			
	Mode of Transportation: Ambulatory <input type="checkbox"/> Wheelchair <input type="checkbox"/> Gurney <input type="checkbox"/>		
	Condition on Discharge:		
	Post op Teaching: (see Discharge Summary)		
	Admission to 1-4: (see Nurses Note)		
INDIVIDUAL EVALUATION/TREATMENT/MANAGEMENT PLAN (see on back)			

PATIENT'S IDENTIFICATION (Use this space for Mechanical imprint)

ALLEN, ANTHONY
40428-053
MCFP SPG MO
DOB 3-2-54

RECORDS MAINTAINED AT			
PATIENT'S NAME (Last, First, Middle initial)			SEX
RELATIONSHIP TO SPONSOR	STATUS		RANK/GRADE
SPONSOR'S NAME		ORGANIZATION	
DEPART./SERVICE	SSN/IDENTIFICATION NO.		DATE OF BIRTH

CHRONOLOGICAL RECORD OF MEDICAL CARE

STANDARD FORM 600 (REV. 5-84)

Prescribed by GSA and ICMR
FIRM (41 CFR) 201-454.505

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)									
INDIVIDUAL EVALUATION/TREATMENT/MANAGEMENT PLAN										
CONTINUATION SHEET										
Goal Statement: PATIENT EDUCATION/DISCHARGE PLANNING for SAME-DAY										
SURGERY:(name of procedure)										
The patient will verbalize/communicate an understanding of the pre-operative procedure and										
any medications/treatments and discharge plan before discharge from the hospital as										
by:										
1. Patient will be able to communicate basic concepts taught.										
2. Patient will demonstrate self-care skills prior to discharge.										
Action Plan: (Include staff name and title)										
A. Assess Educational Level upon Admission.										
B. Collaborate with Other Health Care Members on Educational Needs										
(Lab, Xray, Pt, Rehab, Physicians)										
C. Encourage and Answer Questions about Procedures and Test.										
D. Evaluate Ability to Perform Self Care.										
3. Post Procedure Pain Assessment										
Are you Having Pain? Yes No 0 1 2 3 4 5 6 7 8 9 10										
Location Intensity Frequency Duration -										
Target Date:										
Treatment Review:										
Nurses Signature:										

MEDICAL RECORD

CONSULTATION SHEET

REQUEST

TO: *Dr Rotten* FROM: *Kelly* DATE OF REQUEST:

REASON FOR REQUEST:

39 yo ♂ c large Rt scrotal-inguinal hernia partially reducible

PROVISIONAL DIAGNOSIS:

DOCTOR'S SIGNATURE <i>Kelly</i>	APPROVED	PLACE OF CONSULT <input type="checkbox"/> BEDSIDE <input type="checkbox"/> ON CALL	<input type="checkbox"/> ROUTINE <input type="checkbox"/> TODAY <input type="checkbox"/> 72-HRS <input type="checkbox"/> EMERGENCY
------------------------------------	----------	---	---

CONSULTATION REPORT

EXAMINATION:

Rt manual chest exam

Imp R2H

Re R2H

Dickster

Bono

12 2303

SIGNATURE AND TITLE	DATE
---------------------	------

IDENTIFICATION NO.	ORGANIZATION MCFP Springfield, MO	REGISTER NO.	WARD NO.
--------------------	---	--------------	----------

PATIENT'S IDENTIFICATION

*Allen, Anthony
40428-053*

CONSULTATION SHEET
STANDARD FORM 513

SURGICAL ASSOCIATES OF BRADFORD
51 BOYLSTON STREET
BRADFORD, PA 16701

OFFICE TELEPHONE (814) 368-7125
OFFICE FAX (814) 368-9156

ANTHONY ALLEN 10/27/03

CHIEF COMPLAINT: Large right inguinal hernia.

HISTORY: Mr. Allen is a 39-year old, Jamaican man who has had a slowly enlarging right inguinal hernia for a number of years. It is getting larger. It is no longer fully reducible and has been giving him more pain. He is referred appropriately for hernia evaluation and repair. He moves his bowels well, has no signs of constipation or bowel obstruction. No nausea, vomiting, diarrhea, or any other GI symptoms. He eats well and has maintained a stable weight. He has no difficulty with urination. He also does not have a chronic cough. Source of the history is the patient and records from FCI McKean.

PAST MEDICAL HISTORY:

MEDICATIONS: None.

ALLERGIES: None.

PREVIOUS SURGERY: None.

MEDICAL PROBLEMS: None.

REVIEW OF SYSTEMS: IN GENERAL: No acute change in weight in the last six months, no change in energy level, no recent fall, and no depression. HEAD: No head injuries, chronic headaches, or seizures. EYES: No difficulty with vision, floaters, or bright lights. EARS: No tinnitus or decreased hearing acuity. THROAT: No difficulty with swallowing, difficulty speaking, or thyroid problems. PULMONARY: No chronic cough, phlegm production, hemoptysis, or shortness of breath. CARDIAC: No chest pain, angina, or history of myocardial infarction. GASTROINTESTINAL: No history of peptic ulcer disease, hematemesis, nausea, or vomiting. COLON: No rectal bleeding, change in bowel habits, or colitis. HEPATOBILIARY: No cholecystitis, cholelithiasis, jaundice, hepatitis, or pancreatitis. RENAL: No nephrolithiasis or hematuria. MUSCULOSKELETAL: No decrease in exercise tolerance or focal weakness. EXTREMITIES: No lateralizing weakness or changes in endurance. HEMATOLOGIC: No easy bleeding, bruising, or serious infections. VASCULAR: No amaurosis fugax, TIA, stroke, no history claudication, skin ulcers, rest pain, or tissue loss.

SOCIAL HISTORY: Patient is at FCI McKean and does not smoke.

PHYSICAL EXAM: GENERAL: Patient is a medium height, large boned, muscular male who is in no acute distress. HEENT: He a crew cut and does not wear glasses. EARS, EYES, NOSE, and THROAT have no lesions. NECK: No adenopathy. LUNGS: Clear. HEART: Regular rhythm and rate with no murmurs,

Evaluation/A. Allen

October 27, 2003

Page 2

gallops, or rubs. ABDOMEN: Soft and nontender with no masses. Normal bowel sounds. GENITALIA: Normal uncircumcised penis, two descended testes, and a large soft partially reducible right inguinal hernia, which is inguinoscrotal. It extends down covering the testicle. Testicular atrophy cannot be well evaluated because of the bowel loops, which are around this, cannot be completely removed for full evaluation.

IMPRESSION: (1) Large right inguinoscrotal hernia, which should be repaired. Procedure, risks, and benefits are explained to the patient including, but not limited to bleeding, infection, testicular loss or atrophy, recurrence, and pain. He gives informed consent.

(2) He has been having some pain in the teeth along the right side. This is possibly a dental abscess. This needs to be evaluated and corrected if there is an abscess prior to placement of a prosthetic permanent mesh, which could get contaminated by bacterial seeding at the time of manipulation of the dental abscess.

Thank you very much for the consult.

Nathaniel L. Graham, M.D.

NLG/pl



cc: Dr. Beam

Reviewed by D. Olson, MD
Date: 11/25/03

ST. JOHN'S REGIONAL HEALTH CENTER

1235 E. Cherokee ~ Springfield, Mo. 65804-2263

ANATOMIC PATHOLOGY

Name: **ALLEN, 40428-053**
SJRHCMR:090122235
Pl. Fin No: 12857325
Age: 39 Years
Birthdate: 03/02/1964
Sex: Male

Location: SJ LAB
Client: H MCFP Sensitive L.O.U.
Collected: 01/09/2004
Received: 01/10/2004
Printed: 02/18/2004
Order Physician: Rotton, D. Brent
Copy To:
Admit Physician: Rotton, D. Brent

SURGICAL PATHOLOGY FINAL REPORT

PATHOLOGY NO:
S-04-000614

Specimen Source

A Hernia Sac, Inguinal, Right

MCFP-#8162
Dr. Rotton

Clinical Information

Right inguinal hernia.

Gross Description

Part A. Submitted in a container of formalin labelled "right inguinal hernia" is a tan membranous fragment of tissue measuring 5.4 x 2.2 x 0.4 cm. Representative sections are submitted in A1.

PR /SDC

Microscopic Description

Microscopic examination was performed.

Diagnosis

Hernia sac, right, inguinal, herniorrhaphy
- fibroadipose tissue consistent with hernia sac.

DeFlorio, Daniel, M.D.
(Electronically signed by)
Verified: 01/12/04
DD /AGS

MEDICAL RECORD

CONSULTATION SHEET

REQUEST

TO:

OPTOMETRIST

FROM: (Requesting physician or activity)

Dennis Olson, MD, CD

DATE OF REQUEST

REASON FOR REQUEST (Complaints and findings)

EYE EXAM: HTN

SUBJECTIVE: oppo

blue for

PROVISIONAL DIAGNOSIS

G-240

DOCTOR'S SIGNATURE

D. OLSON, M.D.

APPROVED

PLACE OF CONSULTATION

☐ BEDSIDE☐ ON CALL☐ ROUTINE☐ TODAY☐ 72 HOURS☐ EMERGENCY

CONSULTATION REPORT

RECORD REVIEWED ☐ YES ☐ NOPATIENT EXAMINED ☒ YES ☐ NO

Visual Acuity Distance OD 20/50 OS 20/70
 Near OD 37m OS 37m
 TONOMETRY: OD OS
 Unmeasured

External normal 70

Internal

Refraction OD -1.25 20/20
 OS -1.25 20/20

Diagnosis myopia

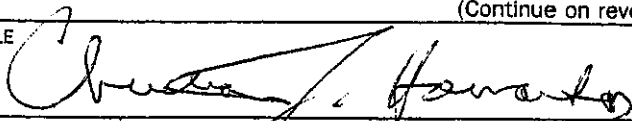
Analysis requires glasses

Plan

order glasses

(Continue on reverse side)

SIGNATURE AND TITLE



DATE

11/24/04

IDENTIFICATION NO.

ORGANIZATION

FCI McKean

REGISTER NO.

40428-053

WARD NO.

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; rank; rate; hospital or medical facility)

Reviewed by D. Olson, MD
 Date 11/24/04

Allen, Anthony

CONSULTATION SHEET

Medical Record

U.S. Bureau of Prisons
Dental/Medical History Form

- | | | |
|--|-----|----|
| 1. Are you presently taking any medication?
If so, what? <u>yes High Blood</u> | Yes | No |
| 2. Are you allergic to or have you had a reaction to any medication or drug? If so, what? _____ | Yes | No |
| 3. Have you been under the care of a physician during the past two years? If so, why? _____ | Yes | No |
| 4. Have you been hospitalized in the past two years?
If so, why? _____ | Yes | No |
| 5. When you walk upstairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you feel very tired? | Yes | No |
| 6. Do your ankles ever swell during the day? | Yes | No |
| 7. Have you ever been treated for a tumor or growth? | Yes | No |
| 8. Have you ever had abnormal bleeding? | Yes | No |
| 9. Have you had any serious difficulty with any previous dental treatment? | Yes | No |

Circle any of the following that you have or have had:

Congenital heart defects	Heart murmur
Heart attack or heart trouble	Angina
Rheumatic Fever	<u>High blood pressure</u> O.
Stroke	Heart pacemaker
Asthma	Epilepsy or seizures
Anemia(blood problems)	Diabetes
Hepatitis	AIDS or HIV infection
Thyroid problems	Emphysema
Chronic bronchitis	Tuberculosis (TB)
Venereal disease (syphilis, gonorrhea)	Psychiatric treatment
Arthritis	Artificial Joint Prosthesis
Artificial Heart Valve	

Do you have any disease, condition, or problem not listed? Yes No

WOMEN ONLY: Are you pregnant? Yes No

Name Anthony Allen

Reg. No. 40478053

Institution FCI McKean

Date 1-7-94

INFORMATION FOR DENTAL SERVICE (To be filled in by referring agency)

27. CHECK HERE IF HOSPITALIZED
FOR DENTAL TREATMENT
☐ ONLY

DIAGNOSIS

HOSPITALIZATION

31. DATE

32. SIGNATURE OF PHYSICIAN

AUTHORIZATION

DD2

AUTHORIZED

35. SIGNATURE OF AUTHORIZING DENTIST

36. TREATMENT RECORD

DIAGNOSIS—TREATMENT—REMARKS

ROBERT KIERSTEAD, DDS

exam. HHX Reviewed, Sc, CO and
 just explained, STWHL, OHL—
 bumps on front teeth.

R.F. KIERSTEAD
 R. Kierstead, DDS

crowns #9-11 little rough spots
 crown ling. #9+11
 crown ling. #9+11 part of crown
 and all rough.

ROBERT KIERSTEAD, DDS

R. Kierstead, DDS

Temp IRM Lower left
 lost IRM.
 #21 Place IRM.

ROBERT KIERSTEAD, DDS

R. Kierstead, DDS

Place IRM - apt for anal
 crown #21, new deep root
 post on tooth, 1.8 cm Sedocaine 3%
 anal or capalite. Attempt to remove
 crown when it is removed.

ROBERT KIERSTEAD, DDS

R. Kierstead, DDS

CLINICAL RECORD		DENTAL TREATMENT RECORD (Continuation)	
DATE	DIAGNOSIS - TREATMENT - REMARKS	SIGNATURE	
09/03/04 0705 hrs	S: "My gum is sensitive." (Pt. points area over #05) PI#: 1/10 O: Med. Hx. Rev'd: NK DA Gingiva above #05 area appears reddened (erythematous) Area in size approximately 1/2 c.m. Pt. admits to having placed aspirin tablets on gingival tissue A: #05 Gingival Tissue: Chemical burn from use of aspirin being placed topically on tissues for relief of pain P: Instructed patient to cease use of placing aspirin on gingiva and explained that aspirin becomes acidic in presence of a solution Use warm (not hot) salt water rinses 2-3 x/day and tissue should heal. Use for 3 days. Take medication that was prescribed yesterday and that he got today Patient understands		
<p>PATIENT'S IDENTIFICATION (For typed or written entries give: Name - last, first, middle; grade; date; hospital or medical facility)</p> <p>Allen, Henry</p>		<p>W.M. Collins, DDS Chief Dental</p> <p>REGISTER NO. 40428-053</p> <p>WARD NO.</p>	

HRSA-237 (4/95)
(REVERSE)

FCI McKean

DENTAL TREATMENT RECORD (Continuation)

DATE	DIAGNOSIS - TREATMENT - REMARKS	SIGNATURE
9/10/04	Continuation of Comprehensive Exam	
1236 hrs	1. Charting 3. Oral Cancer Exam 2. Oral Exam 4. Consultation	
	Pt to return to clinic for rest procedures	<i>[Signature]</i> W.K. Collins, DDS CDO FCI McKean
9/20/04	SOA: RT. Core PT.	
1204 hrs	Med. Hist Rudnik DA.	
	P: 2. Insurance 1:100,000 2% yr x 2	
	occ. pt amalgam &	
	cosalite varnish # 2	
	PT. completed	<i>[Signature]</i> W.K. Collins, DDS CDO FCI McKean

BP-S618.060 CLINICAL DENTAL RECORD CDFRM

AUG 96

U.S. DEPARTMENT OF JUSTICE

FEDERAL BUREAU OF PRISONS

9-10-04

Examination: ☐ Screening ☒ Comprehensive ☐ Periodic

Occlusion Class I

Oral Hygiene Good Fair Poor

CPITN

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

RIGHT 1 2 X 4 5 6 7 8 9 10 11 12 13 14 15 16 LEFT

32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

Head & Neck/Soft Tissue

Fistula located B to #5. No evidence

Additional Findings

D: L

M: 5

F: 10

Treatment Completed

Recommended Treatment Plan

☒ Radiographs 7-8-04

☒ Dental Prophylaxis

☒ Oral Hygiene Instruction

☒ Periodontal Evaluation 0 I II III

re eval 11/1

☐ Oral Surgical Procedures

☐ Endodontic

☒ Restorative

2-op # 20-04

☐ Prosthodontic Evaluation

Patient Name Allen, Anthony Number 410478-053 Sex: M F Age: 40

5-2-04

Dentist Signature

Date

W. K. Collins, DDS

CDO

FCI McKean

FCI McKean



REPRODUCED ON GOVERNMENT PROPERTY

Federal Bureau of Prisons Clinical Dental Records

Date/Time	#	Diagnosis - Treatment - Remarks
09/02/04 1530 hrs		S: Patient seen on 09/01/04; complaining of pain in upper (R) jaw. PI # ^{ENT} 047 ^{DR2} #05
		O: Mx 14 x 12 cm, NKDA Patient seen at open house; patient has been complaining of painful tooth for awhile.
		A: #05, Periapical abscess
		P: Explained to patient that the tooth #05 needs to be extracted. Afterwards, a partial denture could be made to replace not only #05, but the rest of the missing teeth in his maxillary arch. Upon release from prison, implants could be an option. Patient understands but still did not say that he would allow #05 to be extracted.
		Rx: Ibuprofen 500mg x 30, $\bar{11.912h}$ (x 10) Keflex 800mg x 20, $\bar{11.98h}$ (x 10)
		Reviewed By V. Geza, PharmD
		W. K. Collins, D.D.S. FCL McKean

ge template provided in Spanish _____, or _____

Are you currently taking any medication? If so, what? _____	YES	NO
Are you allergic to or have you had a reaction to any medication or drug? If so, what? <u>Antibiotic (unknown)</u>	YES	NO
Have you been under the care of a physician during the past two years? If so, why? <u>same</u>	YES	NO
Have you been hospitalized in the past two years? If so, why? <u>allergic reaction to meds</u>	YES	NO
Do you have or have you ever had a heart murmur or been treated for a heart condition?	YES	NO
Have you ever been treated for a tumor, growth, or cancer?	YES	NO
Have you ever had excessive or prolonged bleeding as a result of a medical condition or medication (ex. Hemophilia or blood thinners)?	YES	NO
Do you have a latex allergy?	YES	NO
Do you currently use tobacco products?	YES	NO
WOMEN ONLY: Are you pregnant?	YES	NO

any of the following that you have had:

<input checked="" type="checkbox"/> Congenital heart defects	<input checked="" type="checkbox"/> Arthritis	<input checked="" type="checkbox"/> Epilepsy or seizures
<input checked="" type="checkbox"/> Heart attack or heart problems	<input checked="" type="checkbox"/> Artificial heart valve	<input checked="" type="checkbox"/> Diabetes
<input checked="" type="checkbox"/> Stroke	<input checked="" type="checkbox"/> Hepatitis (DA DB DC)	<input checked="" type="checkbox"/> AIDS or HIV infection
<input checked="" type="checkbox"/> Rheumatic fever	<input checked="" type="checkbox"/> Any type of transplant	<input checked="" type="checkbox"/> Emphysema
<input checked="" type="checkbox"/> Mitral Valve Prolapse	<input checked="" type="checkbox"/> Steroid treatment	<input checked="" type="checkbox"/> Tuberculosis (TB)
<input checked="" type="checkbox"/> Anemia (blood problems)	<input checked="" type="checkbox"/> Sickle Cell Anemia	<input checked="" type="checkbox"/> Psychiatric treatment
<input checked="" type="checkbox"/> Thyroid problems	<input checked="" type="checkbox"/> Angina	<input checked="" type="checkbox"/> Artificial joint
<input checked="" type="checkbox"/> Chronic bronchitis	<input checked="" type="checkbox"/> High blood pressure	<input checked="" type="checkbox"/> Radiation therapy
<input checked="" type="checkbox"/> STD (syphilis, gonorrhea, herpes)	<input checked="" type="checkbox"/> Heart pacemaker	<input checked="" type="checkbox"/> Asthma
<input checked="" type="checkbox"/> Angio edema	<input checked="" type="checkbox"/> Glucose - 6-phosphate dehydrogenase deficiency	

you have any disease, condition, or problem not listed?

ck any of the following that you have had or applies to you:

<input checked="" type="checkbox"/> Sensitive teeth	<input checked="" type="checkbox"/> Unusual sounds while eating	<input checked="" type="checkbox"/> Burning tongue
<input checked="" type="checkbox"/> Bleeding gums	<input checked="" type="checkbox"/> Snoring	<input checked="" type="checkbox"/> Bad breath
<input checked="" type="checkbox"/> Food impaction	<input checked="" type="checkbox"/> Blisters on lips or mouth	<input checked="" type="checkbox"/> Decayed teeth
<input checked="" type="checkbox"/> Pain around ear	<input checked="" type="checkbox"/> Clenching or grinding	<input checked="" type="checkbox"/> Loose teeth
<input checked="" type="checkbox"/> Tooth ache	<input checked="" type="checkbox"/> Swelling or lumps in mouth/throat	<input checked="" type="checkbox"/> Wear dentures
<input checked="" type="checkbox"/> Wear partial dentures	<input checked="" type="checkbox"/> Address below	
<input checked="" type="checkbox"/> Crown - cap		

Printed Name: <u>Anthony Allen</u>	Signature: <u>Anthony Allen</u>
Reg. No.: <u>4404 28053</u>	Institution: <u>FCI McKean</u>
Date: <u>7/8/04</u>	Updated:

this form may be replicated via WP)

CLINICAL RECORD

DENTAL TREATMENT RECORD (Continuation)

DATE

DIAGNOSIS - TREATMENT - REMARKS

SIGNATURE

5/24/04
0845 HRSSGA Rt. cone pt.
Med Hist RevP. Silocaine 1:100,000 2% x1
L canal rest. #6
Pt. completedW.K. Collins, D.D.S.
G.F. GREEN, D.D.S.
W.K. CollinsWilliam K. Collins, D.D.S.
CDO
FCI McKean

K. Collins, D.D.S.

McKean

07-8-04
1400h

SGA: Rt cone pt

P. Comp. Ht. Soft tissue exam, assessment,
UBWx4. Pt presents w/ mod -> heavy
calc. Ultrasonic Q1-4 selective hand
scale, polish, OHT on brushing +
flossing. NEXT: Comp Exam

J.L. Schroll, RDH

J.L. Schroll, RDH
FCI McKeanW. K. Collins, D.D.S.
CDO
FCI McKean

(Continued On Reverse Side)

PATIENT IDENTIFICATION (For typed or written entries give: Name - last, first, middle; grade; date; hospital or medical

Allen, Anthony

REGISTER NO.

40428-053

WARD NO.

FCI McKean

DENTAL TREATMENT RECORD
HRSA-237 (4/95)

EF

CLINICAL RECORD		DENTAL	
1. CHART		2. ROENTGENOGRAMS	
		<input type="checkbox"/> PERIAPICAL <input type="checkbox"/> BITE WINGS <input type="checkbox"/> OTHER <input type="checkbox"/> LOCAL <input type="checkbox"/> GENERAL	
RIGHT 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17 LEFT		3. PERIODONTITIS <input type="checkbox"/> INCIPENT <input type="checkbox"/> MODERATE <input type="checkbox"/> SEVERE <input type="checkbox"/> LOCAL <input type="checkbox"/> GENERAL	
		4. CALCULUS <input type="checkbox"/> SLIGHT <input type="checkbox"/> MODERATE <input type="checkbox"/> HEAVY	
		5. GINGIVAL PATHOLOGY <input type="checkbox"/> GINGIVITIS <input type="checkbox"/> VINCENT'S INFECTION	
		<input type="checkbox"/> STOMATITIS (Specify)	
		6. FUTURE INDICATED (Include denture needed after indicated extractions)	
		<input type="checkbox"/> FULL UPPER <input type="checkbox"/> FULL LOWER <input type="checkbox"/> PARTIAL UPPER <input type="checkbox"/> PARTIAL LOWER <input type="checkbox"/> REPAIR	
		7. ABNORMALITIES OF OCCLUSION, ANGLES CLASSIFICATION <input type="checkbox"/> ROBERT KIERSTEDT DDS	
		8. DENTAL CLASSIFICATION 9. TYPE OF EXAMINATION	

10. ADDITIONAL FINDINGS

D-2
M-6
F-7

2/1/3
1/1/2

STWHL

* 7BP. med

11. RECOMMENDATIONS

Tx Plan

1)

12. APPROXIMATE TIME REQUIRED FOR DENTAL TREATMENT		13. DATE 9-7-94		14. SIGNATURE OF DENTIST ROBERT KIERSTEDT, DDS <i>Robert Kierstead</i>	
15. GRADE, RATING, OR POSITION	16. TYPE OF BENEFICIARY	17. SEX <input type="checkbox"/> M <input type="checkbox"/> F	18. RACE	19. AGE	20. SERVICE <input type="checkbox"/> INPATIENT <input type="checkbox"/> OUTPATIENT <input type="checkbox"/> OTHER
PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; date; hospital or medical facility)			22. IDENTIFICATION NO.	23. REGISTER NO.	24. WARD NO.

Allen, Anthony
46428-053
FCI McKean

DENTAL

Standard Form 521
521-108